HHA PPS MAILBOX QUESTIONS
VOLUME IV: April 2001 – Batch 1

The questions below, which in some cases have been paraphrased, were sent to *"e-mailto :HHPPS@HCFA.gov"* during the period referenced above. It is our intention to continue to answer questions that come into that mailbox in monthly batches, and post those answers at: *"http://www.hcfa.gov/medlearn/refhha.htm"*. This batch of questions was pulled from the mailbox prior to May 1, 2001. In cases where time is needed to consult internal experts, multiple batches of answers may be released under the same Volume number (same time period or month). Note that questions without broad applicability have been/will be answered/referred individually.

Questions are grouped by topic and not repeated. However, each batch of questions will be listed by topic in order at the beginning of each batch of answers, and a table of cross-references will follow.

Questions by Major Topic

Alphabetical Cross-reference Topics

General Terms/Acronyms

The following terms/acronyms may not be spelled out/explained above or elsewhere in this document:

CMS = The Centers for Medicare and Medicaid Services, new name of HCFA (below).
HH = Home Health
HHA = Home Health Agency
HCFA = Health Care Financing Administration, previous name of the federal agency administering Medicare and Medicaid. Note: The name of the agency was changed to CMS (above).
HCPCS = HCFA Common Procedure Coding System, individual codes representing medical services or items in Form Locator 44 of Medicare claims
HHRG = Home Health Resource Group, the payment group for HH PPS episodes
HIPPS = Health Insurance PPS, a code representing a PPS payment group on a Medicare institutional claim, placed in Form Locator 44
MSA = Metropolitan Statistical Area, a series of codes representing geographic locations put on Medicare HH claims so that payment is commensurate with the location in which services are delivered.
OASIS = Outcome and Assessment Information Set. The standard assessment instrument required by CMS for use in delivering home care.
PPS = Prospective Payment System. A pre-determined method of fee for service payment of bundled services, as opposed to cost reimbursement of individual services, used to pay many types of Medicare providers (hospitals, SNFs, etc.); Medicare pays for home care under a plan of care through a PPS since October 1, 2000.
RAP = Request for Anticipated Payment. The first of two transactions submitted on a UB92 claim form to get the first of two split percentage payments for a HH PPS episode.
RHHI = Regional Home Health Intermediary. Medicare fiscal intermediary specializing in the processing of hospice and home health claims.
SNF = Skilled Nursing Facility.

CONSOLIDATED BILLING

Q1: A patient had physical therapy in a hospital setting when receiving home health care. The hospital bill was denied. How does the hospital bill this service?

A1: Payment for physical therapy services while a beneficiary is under a HH plan of care can only be received under arrangement with the home health agency responsible for that plan of care. This has been the case since October 1, 2000 when both HH PPS and HH consolidated billing went into effect as required by law. If a hospital providing these services after that date does not have a payment

arrangement with the home health agency, they cannot be paid for the services. It is important to communicate with beneficiaries receiving therapy, or their caregivers, regarding their home health status. Hospitals, and all other providers of therapy services billing fiscal intermediaries, also have the ability to use the HIQA inquiry into Medicare's Common Working File (CWF) to determine whether a home health episode is currently open for a beneficiary.

Currently, it is possible that if a beneficiary has been discharged from home care and the home health agency has not yet billed their discharge claim for the home health episode, a therapy claim will be rejected inappropriately. In this case, the claim is rejected and not denied, and can be resubmitted for payment after the home health claim has been received. Medicare systems are being corrected in October 2001 to prevent these therapy claims from being rejected. The corrections are described in Program Memorandum AB-01-70, dated May 1, 2001. Program Memoranda are available on our website at: http://www.hcfa.gov/pubforms/progman.htm.

RATES and PAYMENT

Q2: Since implementing PPS, we have committed a significant amount of labor in tracking RAP/Final submissions and subsequent payments on these submissions. We have also committed the manpower necessary to bill RAPs every day, and finals once a week. We have determined from this extremely time-consuming tracking system that there seems to be no system to how payments are made. It seems adjustments are processed first, limiting cash flows to our agency. There seems to be a significant amount of unexplained holding of billed final claims. Recently, over 102 finals had been held for over 30 days and paid subsequent to our proving that these bills were being held with no reason. Before PPS, we were paid under periodic interim payment (PIP), so getting used to the holding of cash flow has not been easy for us—holding constantly over $400,000 is devastating. We took advantage of the one time extension of our PIP payments in January 2001, but we will be required to pay it back with the 2000 cost report filing. Our assumption was that when the FI got the bugs cleaned out of the system, we would see the payment of RAPs in the 5 to 7 days, and finals in 14 days or less, as was touted prior to October's implementation. My question is how exactly are RAPs and claims being processed, and when is the system going to be corrected?

A2: Throughout the first quarter and into the second quarter of HH PPS, a number of claims processing problems were affecting the timeliness of payment. With a few exceptions that affect a limited number of claims in special scenarios, these problems have been fixed and processing is now more regular. However, it is important to note that due to the great variety of conditions represented by individual claims, payment on a per-claim basis can never be as regular as bi-weekly PIP checks.

RAPs may be processed to payment in 5 to 7 days or less, but then the timing of your intermediary's regular payment cycle may add days before your receive a

check for those RAPs. If your intermediary issues checks on a weekly or bi-weekly basis, RAPs processed immediately after one check is issued must await the issuance of the next regular check. However, since RAPs are not subject to a payment floor, unlike payment for any other kind of Medicare transaction subject to claims processing, these payments are processed significantly faster than others.

Payments for final claims are subject to a payment floor required by law, and will never be released for payment in less than 14 days. Claims payments are also subject to the timing of your intermediary's payment cycle.

You may submit RAPs and claims for beneficiaries whose records are not housed at the local Common Working File host site. In these "out of service area" cases, a one-time query process to locate and transfer that beneficiary's records may add weeks to the payment process of either a RAP or a claim. However, out of service area records would not routinely add time to the processing of RAPs and claims, since once the record is transferred to your intermediary's Common Working File host site, it remains there until called elsewhere.

You should continue talking to your intermediary for explanation. They may be able to suggest changes to the timing of your submission schedule that could speed your payment given variables like their payment cycle.

Q3: SCICs: How are they calculated?

A3: SCICs are the one case where more than one HIPPS code appears on a HH PPS claim, and each HIPPS represents the output of an OASIS assessment done when the patient's condition changes and new physician orders are required during the episode. Payments for significant change in condition (SCIC) claims are calculated based on the number of days of service provided under each HIPPS code reported on the claim. Medicare systems calculate the number of days between the first and last billable service provided under each HIPPS code, and prorate the payment based the numbers of days divided by 60. The results of this calculation for each HIPPS are added together to provide total payment for the episode. Days prior to the first visit in the episode, days between the last visit under one HIPPS code and the first visit under the next, and days after the last visit in the episode are not counted in the SCIC calculation.

For detailed examples of all HH PPS payment calculations, including the SCIC calculation, see Chapter 6 of the "Home Health PPS Training Session" available on the web at: http://www.hcfa.gov/medlearn/refhha.htm. Note that since these instructions were provided, CMS [HCFA] has clarified that SCICs only have to be reported when the HIPPS code changes and when the HHA is not financially disadvantaged in taking care of a patient who condition has deteriorated. In these cases, the episode may be billed entirely under the original HIPPS.

Q4: I was at OASIS training, and was told about a spreadsheet that we can use to calculate SCIC payments to see if we should submit the SCIC or not. I have been trying to locate it, but have been unable. Can you help me?

A4: The OASIS trainer is likely referring to a spreadsheet tool for calculating payments that is available on the website of your RHHI, United Government Services. This tool is available at the following web address:

www.ugsmedicare.com/provider/hhops/040101%20HHARAP.xls.

Another tool that is available for this same purpose is Medicare's PC version of the Pricer software that is used to pay claims in Medicare systems. The PC Pricer is available at: http://www.hcfa.gov/medicare/nm75ght/priceint.htm. If the SCIC calculation indicates that payment for the episode would decrease as a result of reporting the SCIC and the HIPPS code weight increased (i.e., the beneficiary's condition worsened), you are not required to report the SCIC.

EPISODE ADMISSION AND DISCHARGE

Q5. What happens if the end of the episode is on December 6, the patient is discharged from the hospital December 7--could the episode continue without discharging patient? I have seen statements that if the patient remains an inpatient on Day 60, a discharge must occur. Is it because the follow-up was completed prior to inpatient stay?

Q6. Could you please clarify the answer to Q27 in volume I of the HHPPS Billing Questions under "Other HH PPS Information" (uses the December 6 and 7 example). In the scenario presented, the patient has received a re-certification visit during the recertification window, but is hospitalized prior to Day 60 of the episode. Two different discharge situations are presented: (1) the patient is discharged on Day 60 and resumption of care OASIS (ROC) would then done be on Day 61 (the first day of the subsequent continuous episode); (2) the patient is discharged on Day 61, which is Day 1 of the planned subsequent episode, and would then be scheduled for ROC. The question is whether these are ROCs for the planned continuous episode or discharge/readmits. The response given is both are ROC situations in continuous episodes. We have had RAPs rejected with the reason "overlapping dates with inpatient stay" and have found the patient was admitted on Day 1 of a planned continuous episode. It is our understanding a patient cannot be in the hospital at the start of an episode, thus the rejected RAP. How is our hospitalized patient on Day 1 of the continuous episode different from the above-described patient being discharged from the hospital on Day 1 of the subsequent episode? This patient is also in the hospital on the start of the episode.

A5 and 6. If December 6 in the example represented Day 60 of an episode, and therefore the next day would be Day 61, and the patient was in the hospital both of these entire days, you must discharge the patient from home care for Medicare billing purposes. In this case, home care could not be provided until what would be,

at the earliest, Day 62. The reason you must discharge does not have to do with the timing of follow-up care, but instead that there is a gap in the delivery of home care between two episodes (a new episode would have had to be started with care delivered on Day 61, since episodes cannot exceed 60 days). An episode cannot be started on a day when a patient has not at any point been under the care of a HHA.

However, home health billing may occur if the hospital discharges on Day 61 AND the HHA has either assessed the patient for the period starting Day 1 and the assessment did not change the HIPPS code from the prior recertification assessment OR provides care on Day 61. Medicare claims processing systems permit "same-day transfers" among providers, and home care would be continuous if you did not discharge the patient during the previous episode, and resumed care of the patient on the first day of the next episode period (Day 61). This would also be considered continuous care, and therefore 50% of the episode payment would be made on the RAP for the subsequent episode.

While it is true Medicare billing systems were inappropriately rejecting same-day transfers at the beginning of the HH PPS, these systems problems were fixed last year. If you are still having a problem with such billings, you should contact your RHHI for assistance.

Note there has been a recent refinement in Medicare policy in this area. If a patient's assessment changes before any services are delivered under that particular assessment, and there is a gap of day(s) between periods covered by assessments under which services were delivered, care cannot be billed as continuous. Care provided under the next assessment where services are actually delivered will be paid as an initial episode. For example, if the patient above had been re-assessed in the prior episode period, and was in the HHA's care Day 61 though no home care was delivered, and then the patient was hospitalized and released back to the HHA Day 62, and the patient's assessment changed when he/she came back to the HHA, Day 62 would become Day 1 of a initial episode, since no care was performed under the assessment that covered Day 61.

CLAIMS, ELEMENTS AND CODING

Q7. What is the policy on physician-ordered lab work that is brought in by HHAs to hospitals? Who bills the Medicare Program: the Home Health Agency or the Hospital? Who is responsible for obtaining the signed ABN form?

A7. Lab services cannot be billed by HHAs on UB-92 (Form HCFA-1450) home health claims sent to RHHIs. If HHAs want to bill lab services to Medicare, they must obtain laboratory numbers and bill Medicare carriers as laboratories on 1500 claim forms.

Advance Beneficiary Notices (ABNs) must be signed by beneficiaries before Medicare providers either stop or reduce services, because providers believe that

Medicare will not cover the services in question. It is not clear from your question why an ABN would be at issue.

Q8. At your website (**http://www.hcfa.gov/medlearn/refhha.htm**), in the section titled "Home Health Payment System Training Session," you make available a "Listing of HHRGs, HIPPS Codes and Weights" in PDF format. The file name is HHPPSA1.PDF. Can you e-mail me a copy of this in Excel format? We are unable to work with the data otherwise.

A8. In the process of posting the answers to this set of questions, we will simultaneously post an excel version of this table as an attachment to these questions.

Q9. Is there a list that we can download that lists all of the MSAs and their corresponding current wage index for Home Health?

A9. Yes. A table of MSAs and their wage indices for October 2000 through September 2001 can be found in Section IV.B.4 of the HH PPS final rule. The final rule, along with a correction notice with corrected MSAs for this period, can be found at: http://www.hcfa.gov/medlearn/refhha.htm. The update notice for the second year of HH PPS (October 1, 2001 to September 30, 2002) with wage index information for this period can also be found at this same site. There has been no change in MSA codes.

OASIS, COVERAGE and MEDICAL REVIEW

Q10. What are the chances that ROVER software or its contents could be shared with providers? Providers are working at a "grassroots" level to develop chart review tools and criteria in response to the OASIS regulation that requires we ensure OASIS accuracy and consistency, even before PPS became another reason this was critical. Sounds like ROVER already has the criteria, so why reinvent the wheel?

A10. Revisions are currently being made to the ROVER software. Once the revisions are completed, CMS [HCFA] is considering posting the software FYI on the Internet. Concerning your request to use ROVER as a method for ensuring OASIS accuracy and consistency, the software would not be a comprehensive tool to test and monitor the accuracy and consistency of the entire assessment. ROVER was created as a means for RHHI medical reviewers to electronically calculate a case-mix group (HHRG represented by a HIPPS code) when needed as result of medical review. Although RHHIs may consider the entire OASIS information set when conducting reviews, ROVER only addresses items related to Medicare payment.